This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 174004	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 12/27/2012 8:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSAWATOMIE STATE HOSPITAL (174004) for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	92,569	1,467	0	-1,582	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	92,569	1,467	0	-1,582	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/27/2012 8:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 500 STATE HOSPITAL DRIVE	PO Box:			1.00
2.00	City: OSAWATOMIE	State: KS	Zip Code: 66064	County: MIAMI	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	OSAWATOMIE STATE HOSPITAL	174004	28140	4	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
16.01	Hospital-Based Health Clinic - FQHC 1									16.01
16.02	Hospital-Based Health Clinic - FQHC 2									16.02
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	10		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/27/2012 8:32 am

		Beginning:	Ending:	
		1.00	2.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/27/2012 8:32 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/27/2012 8:32 am

		1.00	2.00	3.00	
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00		
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	36,337	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00

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		1.00	2.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00 Name: SOCIAL & REHABILITATION SERVICES	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 5201	141.00
142.00 Street: 915 HARRISON	PO Box:		142.00
143.00 City: TOPEKA	State:	Zip Code: 66612	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	

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		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 12/27/2012 8:32 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Description	Part A Y/N	Part A Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/28/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 12/27/2012 8:32 am

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
			1.00		2.00	
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DAN		MUFICH	41.00
42.00	Enter the employer/company name of the cost report preparer.		OSAWATOMIE AND RAINBOW			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		913-755-7019		DAN.MUFICH@OSH.KS.GOV	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 12/27/2012 8:32 am

		Part B Y/N	Part B Date		
		3.00	4.00		
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/28/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N			21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		INTERIM FINANCE DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

VOLUNTARY CONTACT INFORMATION | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part V | Date/Time Prepared: 12/27/2012 8:32 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	DAN	13.00
14.00	Last Name	MUFICH	14.00
15.00	Title	PROGRAM CONSULTANT	15.00
16.00	Employer	OSH	16.00
17.00	Phone Number	(913)755-7019	17.00
18.00	E-mail Address	DAN.MUFICH@OSH.KS.GOV	18.00
19.00	Department		19.00
20.00	Mailing Address 1	500 STATE HOSPITAL DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	OSAWATOMIE	22.00
23.00	State	KS	23.00
24.00	Zip	66064	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	176	64,416	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		176	64,416	0.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		176	64,416	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0			19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00					25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
26.26	FQHC II	89.01					26.26
26.27	FQHC III	89.02					26.27
27.00	Total (sum of lines 14-26)		176				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	8,802	3,462	64,329		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF Subprovider		0	0			3.00
4.00	HMO IRF Subprovider		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	8,802	3,462	64,329		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	8,802	3,462	64,329		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0		25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
26.26	FQHC II	0	0	0	0		26.26
26.27	FQHC III	0	0	0	0		26.27
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	0		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	463	1.00
2.00	HMO					0	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	396.40	0.00	0	463	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00	0.00	0.00			25.00
26.00	RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
26.26	FQHC II	0.00	0.00	0.00			26.26
26.27	FQHC III	0.00	0.00	0.00			26.27
27.00	Total (sum of lines 14-26)	0.00	396.40	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Discharges (Title XIX)	Discharges (Total All Patients)		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	107	2,270		1.00
2.00	HMO				2.00
3.00	HMO IPF Subprovider				3.00
4.00	HMO IRF Subprovider				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	107	2,270		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
26.26	FQHC II				26.26
26.27	FQHC III				26.27
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		915,427	915,427	0	915,427	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		70,678	70,678	0	70,678	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00401	EMPLOYEE BENEFITS	151,481	6,702,320	6,853,801	0	6,853,801	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,872,694	519,250	2,391,944	0	2,391,944	5.00
6.00	00600	MAINTENANCE & REPAIRS	769,843	475,952	1,245,795	0	1,245,795	6.00
7.00	00700	OPERATION OF PLANT	228,409	1,004,935	1,233,344	0	1,233,344	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,922	29,881	116,803	0	116,803	8.00
9.00	00900	HOUSEKEEPING	384,389	84,326	468,715	0	468,715	9.00
10.00	01000	DIETARY	804,243	580,803	1,385,046	0	1,385,046	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	760,139	136	760,275	0	760,275	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,790	86,277	179,067	0	179,067	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	320,534	4,848	325,382	0	325,382	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,377,694	463,041	10,840,735	-324,930	10,515,805	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,714	34,714	21,401	56,115	54.00
60.00	06000	LABORATORY	138,471	155,461	293,932	40,066	333,998	60.00
66.00	06600	PHYSICAL THERAPY	0	20,866	20,866	0	20,866	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,879	1,879	8,008	9,887	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	267,082	1,139,153	1,406,235	28,578	1,434,813	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	12,771	12,771	0	12,771	89.01
89.02	08903	FQHC III	0	403,960	403,960	226,877	630,837	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,254,691	12,706,678	28,961,369	0	28,961,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,975	0	5,975	0	5,975	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	16,260,666	12,706,678	28,967,344	0	28,967,344	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	915,427		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	70,678		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00401	EMPLOYEE BENEFITS	-1,754,306	5,099,495		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-94,629	2,297,315		5.00
6.00	00600	MAINTENANCE & REPAIRS	-11,224	1,234,571		6.00
7.00	00700	OPERATION OF PLANT	0	1,233,344		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-13,196	103,607		8.00
9.00	00900	HOUSEKEEPING	-7,047	461,668		9.00
10.00	01000	DIETARY	-13,384	1,371,662		10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	760,275		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-28,834	150,233		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,285	314,097		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-334,157	10,181,648		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,115		54.00
60.00	06000	LABORATORY	-12,202	321,796		60.00
66.00	06600	PHYSICAL THERAPY	0	20,866		66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,887		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-22,395	1,412,418		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
89.01	08901	FQHC II	0	12,771		89.01
89.02	08903	FQHC III	0	630,837		89.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,302,659	26,658,710		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,975		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,302,659	26,664,685		200.00

RECLASSIFICATIONS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 12/27/2012 8:32 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OUTSIDE MEDICAL SERVICES				
1.00	ADULTS & PEDIATRICS	30.00	0	7,944	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,401	2.00
3.00	LABORATORY	60.00	0	40,066	3.00
4.00	ELECTROCARDIOLOGY	69.00	0	8,008	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	28,578	5.00
6.00	FQHC III	89.02	0	226,877	6.00
	TOTALS		0	332,874	
500.00	Grand Total: Increases		0	332,874	500.00

RECLASSIFICATIONS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 12/27/2012 8:32 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - OUTSIDE MEDICAL SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	0	332,874	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		0	332,874		
500.00	Grand Total: Decreases		0	332,874		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III Date/Time Prepared: 12/27/2012 8:32 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	286,236	0	0	0	0	1.00
2.00	Land Improvements	1,234,543	0	0	0	0	2.00
3.00	Buildings and Fixtures	32,441,797	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,434,007	0	0	0	-413,835	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,396,583	0	0	0	-413,835	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,396,583	0	0	0	-413,835	10.00

SUMMARY OF CAPITAL

	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	915,427	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,678	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	986,105	0	0	0	0	3.00

COMPUTATION OF RATIOS

	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,441,797	0	32,441,797	0.891268	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,957,786	0	3,957,786	0.108732	0	2.00
3.00	Total (sum of lines 1-2)	36,399,583	0	36,399,583	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/27/2012 8:32 am

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	286,236	0	1.00
2.00	Land Improvements	1,234,543	0	2.00
3.00	Buildings and Fixtures	32,441,797	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	2,847,842	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,810,418	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,810,418	0	10.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	915,427	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	70,678	2.00
3.00	Total (sum of lines 1-2)	0	986,105	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	915,427	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	70,678	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	986,105	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	915,427	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	70,678	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	986,105	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,030	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-280,933			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-10,486	ADMINISTRATIVE & GENERAL	5.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	169,870			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-1,308	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-4,051	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	33.00
34.03	PY VACATION ACCRUAL	A	-1,000,078	EMPLOYEE BENEFITS	4.00	34.03
34.04	PY SALARY ACCRUAL	A	-2,730,876	EMPLOYEE BENEFITS	4.00	34.04
34.06	CY VACATION ACCRUAL	A	873,794	EMPLOYEE BENEFITS	4.00	34.06
34.07	CY SALARY ACCRUAL	A	1,339,435	EMPLOYEE BENEFITS	4.00	34.07
34.08	PY COMP TIME	A	-24,407	EMPLOYEE BENEFITS	4.00	34.08
34.09	PY HOLIDAY ACCRUAL	A	-150,792	EMPLOYEE BENEFITS	4.00	34.09
34.10	CY COMP TIME ACCRUAL	A	18,694	EMPLOYEE BENEFITS	4.00	34.10
34.11	CY HOLIDAY ACCRUAL	A	100,472	EMPLOYEE BENEFITS	4.00	34.11
34.12	LAUNDRY COSTS FROM 17-4010	A	-13,196	LAUNDRY & LINEN SERVICE	8.00	34.12
34.13	LAUNDRY COSTS TRANSFERRED TO 17-4010	A	-6,388	EMPLOYEE BENEFITS	4.00	34.13
34.14	OTHER COSTS TRANSFERRED TO 17-4010	A	-9,693	EMPLOYEE BENEFITS	4.00	34.14
34.15	OTHER COSTS TRANSFERRED TO 17-4010	A	-205,083	EMPLOYEE BENEFITS	4.00	34.15
34.16	OTHER COSTS TRANSFERRED TO 17-4010	A	-252,983	ADMINISTRATIVE & GENERAL	5.00	34.16
34.17	OTHER COSTS TRANSFERRED TO 17-4010	A	-11,224	MAINTENANCE & REPAIRS	6.00	34.17
34.18	OTHER COSTS TRANSFERRED TO 17-4010	A	-7,047	HOUSEKEEPING	9.00	34.18
34.19	OTHER COSTS TRANSFERRED TO 17-4010	A	-12,076	DIETARY	10.00	34.19
34.20	OTHER COSTS TRANSFERRED TO 17-4010	A	-28,834	CENTRAL SERVICES & SUPPLY	14.00	34.20
34.21	OTHER COSTS TRANSFERRED TO 17-4010	A	-7,234	MEDICAL RECORDS & LIBRARY	16.00	34.21
34.22	OTHER COSTS TRANSFERRED TO 17-4010	A	-163,220	ADULTS & PEDIATRICS	30.00	34.22
34.23	OTHER COSTS TRANSFERRED TO 17-4010	A	-12,202	LABORATORY	60.00	34.23
34.24	OTHER COSTS TRANSFERRED TO 17-4010	A	-22,395	DRUGS CHARGED TO PATIENTS	73.00	34.24

ADJUSTMENTS TO EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
34.25	COSTS TRANSFERRED FROM 17-4010	A	109,996	ADULTS & PEDIATRICS	30.00	34.25
34.26	COSTS TRANSFERRED FROM 17-4010	A	40,616	EMPLOYEE BENEFITS	4.00	34.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,302,659			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
34.03	PY VACATION ACCRUAL	0	34.03
34.04	PY SALARY ACCRUAL	0	34.04
34.06	CY VACATION ACCRUAL	0	34.06
34.07	CY SALARY ACCRUAL	0	34.07
34.08	PY COMP TIME	0	34.08
34.09	PY HOLIDAY ACCRUAL	0	34.09
34.10	CY COMP TIME ACCRUAL	0	34.10
34.11	CY HOLIDAY ACCRUAL	0	34.11
34.12	LAUNDRY COSTS FROM 17-4010	0	34.12
34.13	LAUNDRY COSTS TRANSFERRED TO 17-4010	0	34.13
34.14	OTHER COSTS TRANSFERRED TO 17-4010	0	34.14
34.15	OTHER COSTS TRANSFERRED TO 17-4010	0	34.15
34.16	OTHER COSTS TRANSFERRED TO 17-4010	0	34.16
34.17	OTHER COSTS TRANSFERRED TO 17-4010	0	34.17
34.18	OTHER COSTS TRANSFERRED TO 17-4010	0	34.18
34.19	OTHER COSTS TRANSFERRED TO 17-4010	0	34.19
34.20	OTHER COSTS TRANSFERRED TO 17-4010	0	34.20
34.21	OTHER COSTS TRANSFERRED TO 17-4010	0	34.21
34.22	OTHER COSTS TRANSFERRED TO 17-4010	0	34.22
34.23	OTHER COSTS TRANSFERRED TO 17-4010	0	34.23
34.24	OTHER COSTS TRANSFERRED TO 17-4010	0	34.24
34.25	COSTS TRANSFERRED FROM 17-4010	0	34.25
34.26	COSTS TRANSFERRED FROM 17-4010	0	34.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		5.00	ADMINISTRATIVE & GENERAL	ADMIN EXP	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INS	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	SRS HOME OFFICE	3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00		G	KS DEPT OF ADMI	0.00		6.00
7.00		G	SRS HOSPITAL AD	0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		33,941	0	33,941	0		1.00
2.00		36,337	0	36,337	0		2.00
3.00		99,592	0	99,592	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	169,870	0	169,870			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		KS DEPT OF ADMI	0.00		6.00
7.00		SRS HOSPITAL AD	0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:32 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	1,657,504	280,933	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,657,504	280,933	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:32 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		1,376,571	154,100	20,098	1,488,991	74,450	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		1,376,571		20,098	1,488,991	74,450	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:32 am

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	36,337	30,178	1,519,169	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	36,337	30,178	1,519,169	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:32 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	280,933		1.00
2.00		0	0		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	280,933		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	915,427	915,427				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	70,678		70,678			2.00
4.00	00401	EMPLOYEE BENEFITS	5,099,495	25,183	1,944	5,126,622		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,297,315	175,281	13,533	595,970	3,082,099	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,234,571	78,550	6,065	244,996	1,564,182	6.00
7.00	00700	OPERATION OF PLANT	1,233,344	65,135	5,029	72,689	1,376,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,607	28,921	2,233	27,662	162,423	8.00
9.00	00900	HOUSEKEEPING	461,668	5,541	428	122,329	589,966	9.00
10.00	01000	DIETARY	1,371,662	36,139	2,790	255,944	1,666,535	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	61,658	4,760	0	66,418	12.00
13.00	01300	NURSING ADMINISTRATION	760,275	657	51	241,908	1,002,891	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,233	28,013	2,163	29,530	209,939	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,097	18,386	1,420	102,007	435,910	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,181,648	305,863	23,614	3,302,622	13,813,747	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,115	2,786	215	0	59,116	54.00
60.00	06000	LABORATORY	321,796	1,940	150	44,067	367,953	60.00
66.00	06600	PHYSICAL THERAPY	20,866	2,936	227	0	24,029	66.00
69.00	06900	ELECTROCARDIOLOGY	9,887	1,153	89	0	11,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,412,418	3,598	278	84,997	1,501,291	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	12,771	1,327	102	0	14,200	89.01
89.02	08903	FQHC III	630,837	0	0	0	630,837	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,658,710	843,067	65,091	5,124,721	26,578,862	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,975	5,309	410	1,901	13,595	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,488	1,582	0	22,070	192.00
193.00	19300	NONPAID WORKERS	0	35,175	2,716	0	37,891	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	11,388	879	0	12,267	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,664,685	915,427	70,678	5,126,622	26,664,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,082,099					5.00
6.00	00600	MAINTENANCE & REPAIRS	204,429	1,768,611				6.00
7.00	00700	OPERATION OF PLANT	179,861	181,012	1,737,070			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,228	80,373	87,940	351,964		8.00
9.00	00900	HOUSEKEEPING	77,105	15,398	16,847	41,158	740,474	9.00
10.00	01000	DIETARY	217,806	100,431	109,886	8,481	70,403	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	8,680	171,349	187,481	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	131,072	1,827	1,998	0	1,280	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,438	77,848	85,177	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,971	51,095	55,906	0	35,818	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,805,371	850,007	930,035	300,205	595,866	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,726	7,742	8,471	0	5,428	54.00
60.00	06000	LABORATORY	48,089	5,392	5,900	28	3,780	60.00
66.00	06600	PHYSICAL THERAPY	3,140	8,159	8,927	1,055	5,719	66.00
69.00	06900	ELECTROCARDIOLOGY	1,454	3,203	3,505	47	2,245	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	196,210	9,999	10,940	0	7,009	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	1,856	3,687	4,034	19	2,584	89.01
89.02	08903	FQHC III	82,447	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,070,883	1,567,522	1,517,047	350,993	730,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,777	14,753	16,142	971	10,342	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,884	56,937	62,298	0	0	192.00
193.00	19300	NONPAID WORKERS	4,952	97,751	106,955	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,603	31,648	34,628	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,082,099	1,768,611	1,737,070	351,964	740,474	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	DIETARY	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	12.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,173,542					10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	433,928				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,139,068			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	400,402		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	635,700	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,173,542	433,928	1,139,068	400,402	561,383	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,710	54.00
60.00	06000	LABORATORY	0	0	0	0	12,844	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	680	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	52,096	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	837	89.01
89.02	08903	FQHC III	0	0	0	0	5,574	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,173,542	433,928	1,139,068	400,402	635,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,173,542	433,928	1,139,068	400,402	635,700	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00401	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	23,003,554	0	23,003,554		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,193	0	90,193		54.00
60.00	06000	LABORATORY	443,986	0	443,986		60.00
66.00	06600	PHYSICAL THERAPY	51,709	0	51,709		66.00
69.00	06900	ELECTROCARDIOLOGY	22,159	0	22,159		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,777,545	0	1,777,545		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
89.01	08901	FQHC II	27,217	0	27,217		89.01
89.02	08903	FQHC III	718,858	0	718,858		89.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,135,221	0	26,135,221		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,580	0	57,580		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	144,189	0	144,189		192.00
193.00	19300	NONPAID WORKERS	247,549	0	247,549		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	80,146	0	80,146		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	26,664,685	0	26,664,685		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS	0	25,183	1,944	27,127	27,127	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	175,281	13,533	188,814	3,154	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	78,550	6,065	84,615	1,296	6.00
7.00	00700	OPERATION OF PLANT	0	65,135	5,029	70,164	385	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,921	2,233	31,154	146	8.00
9.00	00900	HOUSEKEEPING	0	5,541	428	5,969	647	9.00
10.00	01000	DIETARY	0	36,139	2,790	38,929	1,354	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	61,658	4,760	66,418	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	657	51	708	1,280	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,013	2,163	30,176	156	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,386	1,420	19,806	540	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	305,863	23,614	329,477	17,476	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,786	215	3,001	0	54.00
60.00	06000	LABORATORY	0	1,940	150	2,090	233	60.00
66.00	06600	PHYSICAL THERAPY	0	2,936	227	3,163	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,153	89	1,242	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,598	278	3,876	450	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	1,327	102	1,429	0	89.01
89.02	08903	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	843,067	65,091	908,158	27,117	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,309	410	5,719	10	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,488	1,582	22,070	0	192.00
193.00	19300	NONPAID WORKERS	0	35,175	2,716	37,891	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	11,388	879	12,267	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	915,427	70,678	986,105	27,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	191,968					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,732	98,643				6.00
7.00	00700	OPERATION OF PLANT	11,202	10,096	91,847			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,322	4,483	4,650	41,755		8.00
9.00	00900	HOUSEKEEPING	4,802	859	891	4,883	18,051	9.00
10.00	01000	DIETARY	13,566	5,601	5,810	1,006	1,716	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	541	9,557	9,913	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,164	102	106	0	31	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,709	4,342	4,504	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,548	2,850	2,956	0	873	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,448	47,406	49,175	35,615	14,527	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	481	432	448	0	132	54.00
60.00	06000	LABORATORY	2,995	301	312	3	92	60.00
66.00	06600	PHYSICAL THERAPY	196	455	472	125	139	66.00
69.00	06900	ELECTROCARDIOLOGY	91	179	185	6	55	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,221	558	578	0	171	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	116	206	213	2	63	89.01
89.02	08903	FQHC III	5,135	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,269	87,427	80,213	41,640	17,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	111	823	854	115	252	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	180	3,176	3,294	0	0	192.00
193.00	19300	NONPAID WORKERS	308	5,452	5,655	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	100	1,765	1,831	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	191,968	98,643	91,847	41,755	18,051	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	DIETARY	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	12.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	67,982					10.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	86,429				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	10,391			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	40,887		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	30,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,982	86,429	10,391	40,887	26,998	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	82	54.00
60.00	06000	LABORATORY	0	0	0	0	618	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	33	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	28	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,506	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	40	89.01
89.02	08903	FQHC III	0	0	0	0	268	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,982	86,429	10,391	40,887	30,573	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,982	86,429	10,391	40,887	30,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00401	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	838,811	0	838,811		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576	0	4,576		54.00
60.00	06000	LABORATORY	6,644	0	6,644		60.00
66.00	06600	PHYSICAL THERAPY	4,583	0	4,583		66.00
69.00	06900	ELECTROCARDIOLOGY	1,786	0	1,786		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,360	0	20,360		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
89.01	08901	FQHC II	2,069	0	2,069		89.01
89.02	08903	FQHC III	5,403	0	5,403		89.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	884,232	0	884,232		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,884	0	7,884		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,720	0	28,720		192.00
193.00	19300	NONPAID WORKERS	49,306	0	49,306		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	15,963	0	15,963		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	986,105	0	986,105		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	378,849					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		378,849				2.00
4.00	00401	EMPLOYEE BENEFITS	10,422	10,422	16,109,185			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,540	72,540	1,872,694	-3,082,099	23,582,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	32,508	32,508	769,843	0	1,564,182	6.00
7.00	00700	OPERATION OF PLANT	26,956	26,956	228,409	0	1,376,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,969	11,969	86,922	0	162,423	8.00
9.00	00900	HOUSEKEEPING	2,293	2,293	384,389	0	589,966	9.00
10.00	01000	DIETARY	14,956	14,956	804,243	0	1,666,535	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	25,517	25,517	0	0	66,418	12.00
13.00	01300	NURSING ADMINISTRATION	272	272	760,139	0	1,002,891	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,593	11,593	92,790	0	209,939	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,609	7,609	320,534	0	435,910	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,582	126,582	10,377,694	0	13,813,747	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,153	1,153	0	0	59,116	54.00
60.00	06000	LABORATORY	803	803	138,471	0	367,953	60.00
66.00	06600	PHYSICAL THERAPY	1,215	1,215	0	0	24,029	66.00
69.00	06900	ELECTROCARDIOLOGY	477	477	0	0	11,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,489	1,489	267,082	0	1,501,291	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	549	549	0	0	14,200	89.01
89.02	08903	FQHC III	0	0	0	0	630,837	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	348,903	348,903	16,103,210	-3,082,099	23,496,763	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,197	2,197	5,975	0	13,595	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,479	8,479	0	0	22,070	192.00
193.00	19300	NONPAID WORKERS	14,557	14,557	0	0	37,891	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	4,713	4,713	0	0	12,267	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	915,427	70,678	5,126,622		3,082,099	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.416337	0.186560	0.318242		0.130694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			27,127		191,968	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001684		0.008140	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	263,379					6.00
7.00	00700	OPERATION OF PLANT	26,956	236,423				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,969	11,969	331,253			8.00
9.00	00900	HOUSEKEEPING	2,293	2,293	38,736	157,302		9.00
10.00	01000	DIETARY	14,956	14,956	7,982	14,956	192,987	10.00
12.00	01200	MAINTENANCE OF PERSONNEL	25,517	25,517	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	272	272	0	272	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,593	11,593	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,609	7,609	0	7,609	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,582	126,582	282,540	126,582	192,987	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,153	1,153	0	1,153	0	54.00
60.00	06000	LABORATORY	803	803	26	803	0	60.00
66.00	06600	PHYSICAL THERAPY	1,215	1,215	993	1,215	0	66.00
69.00	06900	ELECTROCARDIOLOGY	477	477	44	477	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,489	1,489	0	1,489	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	549	549	18	549	0	89.01
89.02	08903	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	233,433	206,477	330,339	155,105	192,987	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,197	2,197	914	2,197	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,479	8,479	0	0	0	192.00
193.00	19300	NONPAID WORKERS	14,557	14,557	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	4,713	4,713	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,768,611	1,737,070	351,964	740,474	2,173,542	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.715080	7.347297	1.062523	4.707340	11.262634	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,643	91,847	41,755	18,051	67,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.374529	0.388486	0.126052	0.114754	0.352262	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			12.00	13.00	14.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00401	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
12.00	01200	MAINTENANCE OF PERSONNEL	6					12.00
13.00	01300	NURSING ADMINISTRATION	0	2,080				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	25,872,716		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6	2,080	100	22,847,934		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	69,614		54.00
60.00	06000	LABORATORY	0	0	0	522,763		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,693		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,440		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,120,321		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
89.01	08901	FQHC II	0	0	0	34,074		89.01
89.02	08903	FQHC III	0	0	0	226,877		89.02
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6	2,080	100	25,872,716		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	433,928	1,139,068	400,402	635,700		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	72,321.333333	547.628846	4,004.020000	0.024570		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,429	10,391	40,887	30,573		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14,404.833333	4.995673	408.870000	0.001182		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,003,554		23,003,554	0	23,003,554	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,193		90,193	0	90,193	54.00
60.00	06000	LABORATORY	443,986		443,986	0	443,986	60.00
66.00	06600	PHYSICAL THERAPY	51,709	0	51,709	0	51,709	66.00
69.00	06900	ELECTROCARDIOLOGY	22,159		22,159	0	22,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,777,545		1,777,545	0	1,777,545	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
89.01	08901	FQHC II	27,217		27,217	0	27,217	89.01
89.02	08903	FQHC III	718,858		718,858	0	718,858	89.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,135,221	0	26,135,221	0	26,135,221	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,135,221	0	26,135,221	0	26,135,221	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,847,934		22,847,934			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,014	8,600	69,614	1.295616	0.000000	54.00
60.00	06000	LABORATORY	455,763	67,000	522,763	0.849306	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	21,193	6,500	27,693	1.867223	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	22,240	1,200	23,440	0.945350	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,120,321	0	2,120,321	0.838338	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
89.01	08901	FQHC II	34,074	1	34,075			89.01
89.02	08903	FQHC III	226,877	1	226,878			89.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,789,416	83,302	25,872,718			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,789,416	83,302	25,872,718			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 174004	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am
Title XVIII	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio 11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.295616		54.00
60.00	06000	LABORATORY	0.849306		60.00
66.00	06600	PHYSICAL THERAPY	1.867223		66.00
69.00	06900	ELECTROCARDIOLOGY	0.945350		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.838338		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
89.01	08901	FQHC II			89.01
89.02	08903	FQHC III			89.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,003,554		23,003,554	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,193		90,193	0	0	54.00
60.00	06000	LABORATORY	443,986		443,986	0	0	60.00
66.00	06600	PHYSICAL THERAPY	51,709	0	51,709	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	22,159		22,159	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,777,545		1,777,545	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
89.01	08901	FQHC II	27,217		27,217	0	0	89.01
89.02	08903	FQHC III	718,858		718,858	0	0	89.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,135,221	0	26,135,221	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,135,221	0	26,135,221	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,847,934		22,847,934			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,014	8,600	69,614	1.295616	0.000000	54.00
60.00	06000	LABORATORY	455,763	67,000	522,763	0.849306	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	21,193	6,500	27,693	1.867223	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	22,240	1,200	23,440	0.945350	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,120,321	0	2,120,321	0.838338	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
89.01	08901	FQHC II	34,074	1	34,075	0.798738	0.000000	89.01
89.02	08903	FQHC III	226,877	1	226,878	3.168478	0.000000	89.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,789,416	83,302	25,872,718			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,789,416	83,302	25,872,718			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
89.01	08901	FQHC II	0.000000		89.01
89.02	08903	FQHC III	0.000000		89.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	838,811	0	838,811	64,329	13.04	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	04500	NURSING FACILITY	0		0	0	0.00	45.00
200.00		Total (lines 30-199)	838,811		838,811	64,329		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	8,802	114,778		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	8,802	114,778		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,576	69,614	0.065734	19,618	1,290	54.00
60.00	06000	LABORATORY	6,644	522,763	0.012709	100,354	1,275	60.00
66.00	06600	PHYSICAL THERAPY	4,583	27,693	0.165493	5,175	856	66.00
69.00	06900	ELECTROCARDIOLOGY	1,786	23,440	0.076195	5,254	400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,360	2,120,321	0.009602	262,366	2,519	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
89.01	08901	FQHC II	2,069	34,075	0.060719	0	0	89.01
89.02	08903	FQHC III	5,403	226,878	0.023815	0	0	89.02
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	45,421	3,024,784		392,767	6,340	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,329	0.00	8,802	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	64,329		8,802	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
89.01	08901	FQHC II		0	0	0	0	89.01
89.02	08903	FQHC III		0	0	0	0	89.02
90.00	09000	CLINIC		0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	92.00
200.00		Total (lines 50-199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,614	0.000000	0.000000	19,618	54.00
60.00	06000	LABORATORY	0	522,763	0.000000	0.000000	100,354	60.00
66.00	06600	PHYSICAL THERAPY	0	27,693	0.000000	0.000000	5,175	66.00
69.00	06900	ELECTROCARDIOLOGY	0	23,440	0.000000	0.000000	5,254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,120,321	0.000000	0.000000	262,366	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
89.01	08901	FQHC II	0	34,075	0.000000	0.000000	0	89.01
89.02	08903	FQHC III	0	226,878	0.000000	0.000000	0	89.02
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	3,024,784			392,767	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,564	0		0	54.00
60.00	06000	LABORATORY	0	66,735	0		0	60.00
66.00	06600	PHYSICAL THERAPY	0	6,481	0		0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,073	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
89.01	08901	FQHC II	0	0	0		0	89.01
89.02	08903	FQHC III	0	0	0		0	89.02
90.00	09000	CLINIC	0	0	0		0	90.00
91.00	09100	EMERGENCY	0	0	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		0	92.00
200.00		Total (lines 50-199)	0	82,853	0		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
89.01	08901	FQHC II	0	0	89.01
89.02	08903	FQHC III	0	0	89.02
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.295616	8,564	0	0		54.00
60.00	06000	LABORATORY	0.849306	66,735	0	0		60.00
66.00	06600	PHYSICAL THERAPY	1.867223	6,481	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.945350	1,073	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.838338	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
89.01	08901	FQHC II	0.000000					89.01
89.02	08903	FQHC III	0.000000					89.02
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.000000	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0		92.00
200.00		Subtotal (see instructions)		82,853	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		82,853	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,096	0	0		54.00
60.00	06000	LABORATORY	56,678	0	0		60.00
66.00	06600	PHYSICAL THERAPY	12,101	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	1,014	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
89.01	08901	FQHC II	0	0	0		89.01
89.02	08903	FQHC III	0	0	0		89.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Subtotal (see instructions)	80,889	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	80,889	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	64,329	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	64,329	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	64,329	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,802	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	23,003,554	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23,003,554	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	22,847,934	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	22,847,934	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.006811	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	355.17	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	23,003,554	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	357.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,147,507	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,147,507	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	345,229	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,492,736	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	114,778	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,340	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	121,118	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,371,618	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	838,811	23,003,554	0.036464	0	0	90.00
91.00	Nursing School cost	0	23,003,554	0.000000	0	0	91.00
92.00	Allied health cost	0	23,003,554	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,003,554	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	64,329	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	64,329	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	64,329	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,462	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	23,003,554	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23,003,554	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	22,847,934	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	22,847,934	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.006811	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	355.17	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	23,003,554	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	357.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,237,977	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,237,977	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	113,375	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,351,352	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,125,264		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.295616	19,618	25,417	54.00
60.00	06000	LABORATORY	0.849306	100,354	85,231	60.00
66.00	06600	PHYSICAL THERAPY	1.867223	5,175	9,663	66.00
69.00	06900	ELECTROCARDIOLOGY	0.945350	5,254	4,967	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.838338	262,366	219,951	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
89.01	08901	FQHC II	0.000000		0	89.01
89.02	08903	FQHC III	0.000000		0	89.02
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		392,767	345,229	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		392,767		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,228,850		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.295616	5,387	6,979	54.00
60.00	06000	LABORATORY	0.849306	23,257	19,752	60.00
66.00	06600	PHYSICAL THERAPY	1.867223	1,648	3,077	66.00
69.00	06900	ELECTROCARDIOLOGY	0.945350	764	722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.838338	89,332	74,890	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
89.01	08901	FQHC II	0.798738	1,585	1,266	89.01
89.02	08903	FQHC III	3.168478	2,111	6,689	89.02
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		124,084	113,375	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		124,084		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E Part B Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	80,889	2.00
3.00	PPS payments	23,469	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	23,469	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,891	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	21,578	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	21,578	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	21,578	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	2,095	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,467	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	728	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	23,045	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	23,045	40.00
41.00	Interim payments	21,578	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	1,467	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 174004	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 12/27/2012 8:32 am
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 12/27/2012 8:32 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,615,498		21,578	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/09/2011	14,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		14,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,629,598		21,578	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		92,569		1,467	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,722,167		23,045	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 174004	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part II Date/Time Prepared: 12/27/2012 8:32 am
	Title XVIII	Hospital	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	5,956,785	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	175.762295	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	5,956,785	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	5,956,785	16.00
17.00	Primary payer payments	312	17.00
18.00	Subtotal (line 16 less line 17).	5,956,473	18.00
19.00	Deductibles	251,855	19.00
20.00	Subtotal (line 18 minus line 19)	5,704,618	20.00
21.00	Coinsurance	317,423	21.00
22.00	Subtotal (line 20 minus line 21)	5,387,195	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	487,670	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	341,369	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	321,617	25.00
26.00	Subtotal (sum of lines 22 and 24)	5,728,564	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-6,397	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	5,722,167	31.00
32.00	Interim payments	5,629,598	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	92,569	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-3 Part VII Date/Time Prepared: 12/27/2012 8:32 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,351,352		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,351,352	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,351,352	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,228,850		8.00
9.00	Ancillary service charges	124,084	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,352,934	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,352,934	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,582	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,351,352	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,351,352	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,351,352	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,351,352	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,351,352	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,351,352	0	40.00
41.00	Interim payments	1,352,934	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	-1,582	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 12/27/2012 8:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,235,101	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,600,287	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	250,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,085,388	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	286,236	0	0	0	12.00
13.00	Land improvements	1,237,543	0	0	0	13.00
14.00	Accumulated depreciation	-1,135,162	0	0	0	14.00
15.00	Buildings	34,988,061	0	0	0	15.00
16.00	Accumulated depreciation	-24,338,634	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,020,173	0	0	0	19.00
20.00	Accumulated depreciation	-1,762,904	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,295,313	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,380,701	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	70,754	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,754	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	70,754	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,309,947				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,309,947	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,380,701	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 12/27/2012 8:32 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		17,144,051		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,834,104			2.00
3.00	Total (sum of line 1 and line 2)		14,309,947		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		14,309,947		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,309,947		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 12/27/2012 8:32 am

		Endowment Fund		Plant Fund		
		5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)		0		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		0		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts I & II | Date/Time Prepared: 12/27/2012 8:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,847,934		22,847,934	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,847,934		22,847,934	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,847,934		22,847,934	17.00
18.00	Ancillary services	3,702,223	83,302	3,785,525	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
21.01	FQHC II	0	0	0	21.01
21.02	FQHC III	0	0	0	21.02
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,550,157	83,302	26,633,459	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,967,344		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,967,344		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 174004 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-3 | Date/Time Prepared: 12/27/2012 8:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,633,459	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,258,471	2.00
3.00	Net patient revenues (line 1 minus line 2)	5,374,988	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,967,344	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-23,592,356	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	203	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	1,030	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,308	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,051	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	20,751,660	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	20,758,252	25.00
26.00	Total (line 5 plus line 25)	-2,834,104	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,834,104	29.00